UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

CYTOGAM (cytomeglavirus immune globulin)

Patient name:_____Medicaid or SS#_____

Physician Name:_____ Contact person:_____

Phone#:_____Ext. and options_____Fax#_____

Pharmacy_____Pharmacy Phone#:_____

All information to be legible, complete and correct or form will be returned

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TELEPHONE AUTHORIZATION OR WRITTEN REQUEST

CRITERIA:

- For prophylaxis of cytomeglovirus
- **DOCUMENTED** transplantation of kidney, lung, liver, pancreas or heart

AUTHORIZATION:

6 months

RE-AUTHORIZATION:

Telephone request from physician's office